FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040816

Facility Name: EMERALD PARK HEALTH CARE CENTER

Address: 9125 SOUTH PULASKI RD. (Number) EVERGREEN PARK (City) 60805 (Zip Code)

County: COOK

Telephone Number: (708) 425-3400 **Fax #** (708) 425-5086

IDPA ID Number: 363473443001

Date of Initial License for Current Owners: 02/11/1987

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	163	Skilled (SNF)	163	59,658	1
2		Skilled Pediatric (SNF/PED)			2
3	86	Intermediate (ICF)	86	31,476	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	249	TOTALS	249	91,134	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,935	76	8,092	16,103	8
9	SNF/PED					9
10	ICF	71,411	426	153	71,990	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	79,346	502	8,245	88,093	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.66%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/11/1987

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/1996 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 8,092

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTE # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	264,016	36,384	12,323	312,723		312,723		312,723			1
2	Food Purchase		348,628		348,628	(11,621)	337,007	(1,455)	335,552			2
3	Housekeeping	296,841	34,369		331,210		331,210		331,210			3
4	Laundry	91,143	22,228	5,257	118,628		118,628	244	118,872			4
5	Heat and Other Utilities			113,424	113,424		113,424	111	113,535			5
6	Maintenance	71,966	82,307	53,083	207,356		207,356	7,035	214,391			6
7	Other (specify):*			24,302	24,302		24,302	55	24,357			7
8	TOTAL General Services	723,966	523,916	208,389	1,456,271	(11,621)	1,444,650	5,990	1,450,640			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,373,879	68,946	20,530	2,463,355		2,463,355		2,463,355			10
10a	Therapy	62,061		15,850	77,911		77,911		77,911			10a
11	Activities	138,006	10,999	2,730	151,735		151,735		151,735			11
12	Social Services	264,489		5,300	269,789		269,789		269,789			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,838,435	79,945	56,410	2,974,790		2,974,790		2,974,790			16
	C. General Administration											
17	Administrative	121,117		56,000	177,117		177,117	(60,138)	116,979			17
18	Directors Fees											18
19	Professional Services			75,319	75,319		75,319	9,409	84,728			19
20	Dues, Fees, Subscriptions & Promotions			23,459	23,459		23,459	(3,873)	19,586			20
21	Clerical & General Office Expenses	131,789	34,623	128,637	295,049		295,049	(76,455)	218,594			21
22	Employee Benefits & Payroll Taxes			691,958	691,958	11,621	703,579		703,579			22
23	Inservice Training & Education							98	98			23
24	Travel and Seminar			5,331	5,331		5,331		5,331			24
25	Other Admin. Staff Transportation			8,297	8,297		8,297	989	9,286			25
26	Insurance-Prop.Liab.Malpractice			128,158	128,158		128,158	511	128,669			26
27	Other (specify):*			251,203	251,203		251,203	(243,603)	7,600			27
28	TOTAL General Administration	252,906	34,623	1,368,362	1,655,891	11,621	1,667,512	(373,062)	1,294,450			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,815,307	638,484	1,633,161	6,086,952		6,086,952	(367,072)	5,719,880			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: EMERALD PARK HEALTH CARE CENTER #0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	12,323	
	REPAIRS & MAINTENANCE		0	
			0	12,323
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		5,257	
			0	5,257
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		43,786	
	ELECTRICITY		47,965	
	WATER		21,673	
	CABLE TV - LOBBY		0	
			0	113,424
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,064	
	PAINTING & DECORATING		269	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		29,460	
	ELEVATOR MAINTENANCE & REPAIR		9,724	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		5,269	
	FIRE SERVICE		4,297	
			0	
			0	
			0	53,083
7	**OTHER**			
	SCAVENGER		11,326	
	SECURITY SERVICE		12,976	24,302
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,000	12,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,128	
	PHARMACY CONSULTANT	XVIII B 39-2	12,702	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		3,700	
			0	20,530
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	15,850	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	15,850
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,730	
			0	2,730
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	5,300	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	5,300
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER **#0040816** **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	56,000	56,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	15,658	
	ADMINISTRATIVE CONSULTANTS	XIX C	2,000	
	PROFESSIONAL FEES	XIX C	57,661	
			0	75,319
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	0	
	EMPLOYEE WANT ADS	XIX F	2,854	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	9,465	
	LICENSES & PERMITS	XIX F	4,203	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	250	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,507	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,680	23,459
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		946	
	EQUIPMENT REPAIR & MAINTENANCE		6,014	
	OUTSIDE CLERICAL SERVICES		21,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	31,396	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		20,297	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		48,984	128,637

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	288,091	
	UNEMPLOYMENT COMPENSATION	XIX D	109,079	
	WORKERS COMPENSATION INSURANCI	XIX D	129,249	
	HOSPITALIZATION INSURANCE	XIX D	126,254	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,369	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	36,916	
	CHICAGO HEAD TAX	XIX D	0	691,958
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	5,331	
	TRAVEL	XIX G	0	
			0	
			0	5,331
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		8,297	8,297
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		128,158	128,158
27	**OTHER**			
	BAD DEBTS	VI 24	251,203	
				251,203

GRAND TOTAL COLUMN 3 OTHER 1,633,161

EMERALD PARK HEALTH CARE CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	348,628
LESS SALES TAX	(1,455)
NET FOOD	347,173
TOTAL PATIENT CENSUS	88,093
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	264279
ADD # EMPLOYEE MEALS/DAY	25
TIME # DAYS	366
TOTAL EMPLOYEE MEALS	9150

PATIENT MEALS	264279
ADD EMPLOYEE MEALS	9150
TOTAL MEALS/YEAR	273429
NET FOOD	347173
DIVIDE TOTAL MEALS/YEAR	273429
COST PER MEAL	1.27
TIME EMPLOYEE MEALS	9150
EMPLOYEE MEAL RECLASSIFICATION	11621

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER #0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			129,977	129,977		129,977	152,134	282,111			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			268	268		268	526,706	526,974			32
33	Real Estate Taxes							437,228	437,228			33
34	Rent-Facility & Grounds			1,100,966	1,100,966		1,100,966	(1,100,966)				34
35	Rent-Equipment & Vehicles			34,642	34,642		34,642	6,937	41,579			35
36	Other (specify):* OFFICE RENT			3,500	3,500		3,500	(3,500)				36
37	**TOTAL Ownership**			1,269,353	1,269,353		1,269,353	18,539	1,287,892			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		236,367	363,072	599,439		599,439		599,439			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			136,702	136,702		136,702		136,702			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		236,367	499,774	736,141		736,141		736,141			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,815,307	874,851	3,402,288	8,092,446		8,092,446	(348,533)	7,743,913			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,729)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,455)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(250)	20		17
18	Fines and Penalties	(31,396)	21		18
19	Entertainment		20		19
20	Contributions	(5,007)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(251,203)	27		24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5-A	(65,091)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (367,131)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	18,598		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 18,598		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (348,533)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

EMERALD PARK HEALTH CARE CENTER

ID# 0040816

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 3893	6	1
2	MARKETING SALARIES	(20,000)	21	2
3	STAFF DEVELOPMENT	(48,984)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(65,091)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,455)	0	0	0	0	0	0	0	0	0	0	(1,455)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	244	0	0	0	0	0	0	0	0	244	4
5	Heat and Other Utilities	0	111	0	0	0	0	0	0	0	0	0	111	5
6	Maintenance	3,893	282	2,860	0	0	0	0	0	0	0	0	7,035	6
7	Other (specify):*	0	12	43	0	0	0	0	0	0	0	0	55	7
8	**TOTAL General Services**	2,438	405	3,147	0	0	0	0	0	0	0	0	5,990	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	9,463	(69,601)	0	0	0	0	0	0	0	(60,138)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	18	9,168	223	0	0	0	0	0	0	0	9,409	19
20	Fees, Subscriptions & Promotions	(5,257)	0	1,384	0	0	0	0	0	0	0	0	(3,873)	20
21	Clerical & General Office Expenses	(100,380)	49	13,091	10,785	0	0	0	0	0	0	0	(76,455)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	98	0	0	0	0	0	0	0	0	98	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	678	311	0	0	0	0	0	0	0	989	25
26	Insurance-Prop.Liab.Malpractice	0	59	452	0	0	0	0	0	0	0	0	511	26
27	Other (specify):*	(251,203)	0	6,114	1,486	0	0	0	0	0	0	0	(243,603)	27
28	**TOTAL General Administration**	(356,840)	126	40,448	(56,796)	0	0	0	0	0	0	0	(373,062)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(354,402)	531	43,595	(56,796)	0	0	0	0	0	0	0	(367,072)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(12,729)	341	362	164,160	0	0	0	0	0	0	0	152,134	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	444	0	526,262	0	0	0	0	0	0	0	526,706	32
33	Real Estate Taxes	0	478	0	436,750	0	0	0	0	0	0	0	437,228	33
34	Rent-Facility & Grounds	0	0	0	(1,100,966)	0	0	0	0	0	0	0	(1,100,966)	34
35	Rent-Equipment & Vehicles	0	34	6,004	899	0	0	0	0	0	0	0	6,937	35
36	Other (specify):*	0	(3,500)	0	0	0	0	0	0	0	0	0	(3,500)	36
37	TOTAL Ownership	(12,729)	(2,203)	6,366	27,105	0	0	0	0	0	0	0	18,539	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(367,131)	(1,672)	49,961	(29,691)	0	0	0	0	0	0	0	(348,533)	45

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MARVIN MERMELSTEIN	24.50	SEE ATTACHED SCHEDULE		EKS MANAGEMENT	LINCOLNWOOD	MANAGEMENT
DORREN MERMELSTEIN	24.50			EMI ENTERPRISES	LINCOLNWOOD	CONSULTANT
MORRIS ESFORMES	51.00			M. MERMELSTEIN		
				PARTNERSHIP	LINCOLNWOOD	REAL ESTATE
				IME REALTY CORP.	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	36	OFFICE RENT	$ 3,500	IME REALTY CORP.		$	$ (3,500)	1
2	V	5	UTILITIES				111	111	2
3	V	6	REPAIRS/MAINT				282	282	3
4	V	7	ALARM SERVICE				12	12	4
5	V	19	PROFESSIONAL FEES				18	18	5
6	V	21	OFFICE EXPENSE				49	49	6
7	V	26	INSURANCE				59	59	7
8	V	30	DEPRECIATION (SL)				341	341	8
9	V	32	INTEREST				444	444	9
10	V	33	RE TAX				478	478	10
11	V	35	STORAGE FEES				34	34	11
12	V								12
13	V								13
14	Total			$ 3,500			$ 1,828	$ * (1,672)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OUTSIDE CLERICAL	$ 21,000	EKS MANAGEMENT, INC		$	$ (21,000)	15
16	V	6	PAINTERS SALARIES				2,860	2,860	16
17	V	7	SCAVENGER				43	43	17
18	V	17	CFO SALARY				9,463	9,463	18
19	V	19	PROFESSIONAL FEES				9,168	9,168	19
20	V	20	WANT ADS/BACKGR CKS				1,384	1,384	20
21	V	21	TOTAL OFFICE				34,091	34,091	21
22	V	23	SEMINARS				98	98	22
23	V	25	TRANSPORTATION				678	678	23
24	V	26	INSURANCE				452	452	24
25	V	27	EMPLOYEE BENEFITS				6,114	6,114	25
26	V	30	DEPRECIATION (SL)				362	362	26
27	V	35	EQUIPMENT RENT				6,004	6,004	27
28	V	4	HOUSEKEEPING SALARIES				244	244	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 21,000			$ 70,961	$ * 49,961	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 1,100,966	M. MERMELSTEIN PARTNERSHIP		$	$ (1,100,966)	15
16	V	30	SL DERPESIATION				164,160	164,160	16
17	V	32	INTEREST				526,262	526,262	17
18	V	33	REAL ESTATE TAXES				436,750	436,750	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	17	MANAGEMENT FEES	88,093	EMI ENTERPRISES, INC			(88,093)	27
28	V	17	OFFICERS SALARY				18,492	18,492	28
29	V	19	ACCOUNTING FEES				223	223	29
30	V	21	TOTAL OFFICE				10,785	10,785	30
31	V	25	TRANSPORTATION				311	311	31
32	V	27	EMPLOYEE BENEFITS				1,486	1,486	32
33	V	35	AUTO LEASE				899	899	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,189,059			$ 1,159,368	$ * (29,691)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number EMERALD PARK HEALTH CARE CENT # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	MARVIN MERMELSTEIN		ADMINISTRAT	24.50	SEE ATTACHED			MGMT FEES	$ 33,000	17-3	1
2	MORRIS ESFORMES		ADMINISTRAT	51.00				MGMT FEES	23,000	17-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 56,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT, INC
Street Address: 6865 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTERS SALARIES	PATIENT DAYS	881,303	14	$ 28,615	$ 28,615	88,093	$ 2,860	1
2	7	SCAVENGER	PATIENT DAYS	881,303	14	429		88,093	43	2
3	17	CFO SALARY	PATIENT DAYS	881,303	14	94,671	94,671	88,093	9,463	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	881,303	14	91,723	65,670	88,093	9,168	4
5	20	WANT ADS/BACKGR CKS	PATIENT DAYS	881,303	14	13,841		88,093	1,384	5
6	21	TOTAL OFFICE	PATIENT DAYS	881,303	14	341,059	251,740	88,093	34,091	6
7	23	SEMINARS	PATIENT DAYS	881,303	14	984		88,093	98	7
8	25	TRANSPORTATION	PATIENT DAYS	881,303	14	6,783		88,093	678	8
9	26	INSURANCE	PATIENT DAYS	881,303	14	4,521		88,093	452	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	881,303	14	61,166		88,093	6,114	10
11	30	DEPRECIATION (SL)	PATIENT DAYS	881,303	14	3,617		88,093	362	11
12	35	EQUIPMENT RENT	PATIENT DAYS	881,303	14	60,061		88,093	6,004	12
13	4	HOUSEKEEPING SALARIES	PATIENT DAYS	881,303	14	2,437		88,093	244	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 709,907	$ 440,696		$ 70,961	25

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES, INC
Street Address: 6865 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	881,303	14	$ 185,000	$ 185,000	88,093	$ 18,492	1
2	19	ACCOUNTING FEES	PATIENT DAYS	881,303	14	2,230		88,093	223	2
3	21	TOTAL OFFICE	PATIENT DAYS	881,303	14	107,899	87,197	88,093	10,785	3
4	25	TRANSPORTATION	PATIENT DAYS	881,303	14	3,109		88,093	311	4
5	35	AUTO LEASE	PATIENT DAYS	881,303	14	8,991		88,093	899	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	881,303	14	14,871		88,093	1,486	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 322,100	$ 272,197		$ 32,196	25

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP.
Street Address: 6865 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	312,263	14	$ 9,942	$	3,500	$ 111	1
2	6	REPAIRS/MAINT	PATIENT DAYS	312,263	14	25,152		3,500	282	2
3	7	ALARM SERVICE	PATIENT DAYS	312,263	14	1,056		3,500	12	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	312,263	14	1,575		3,500	18	4
5	21	OFFICE EXPENSE	PATIENT DAYS	312,263	14	4,388		3,500	49	5
6	26	INSURANCE	PATIENT DAYS	312,263	14	5,225		3,500	59	6
7	30	DEPRECIATION (SL)	PATIENT DAYS	312,263	14	30,446		3,500	341	7
8	32	INTEREST	PATIENT DAYS	312,263	14	39,619		3,500	444	8
9	33	RE TAX	PATIENT DAYS	312,263	14	42,669		3,500	478	9
10	35	STORAGE FEES	PATIENT DAYS	312,263	14	3,011		3,500	34	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 163,083	$		$ 1,828	25

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTE # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY: M.MERMELSTEIN PARTNERSHIP						$	$			$	1
2	COLE TAYLOR BANK		X	MORTGAGE	$84684.69	01/02	7,300,000	7,001,462	02/07	7.1250	511,662	2
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		73,000	30,417			14,600	3
4												4
5												5
	Working Capital											
6	CHRYSLER FINANCIAL		X	AUTO LOAN	$810.00	02/02	27,499	2,431	02/05	3.9000	268	6
7												7
8	MGMT ALLOCATION										444	8
9	TOTAL Facility Related				$810.00		$ 7,400,499	$ 7,034,310			$ 526,974	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 7,400,499	$ 7,034,310			$ 526,974	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 337,100	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 385,000	2
3. Under or (over) accrual (line 2 minus line 1).		$ 47,900	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 388,850	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 436,750	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	266,222	8
	2000	273,716	9
	2001	283,073	10
	2002	337,100	11
	2003	385,000	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME EMERALD PARK HEALTH CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0040816

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-02-300-046-0000	NURSING HOME	$ 39,979.16	$ 39,979.16
2.	24-02-300-047-0000	NURSING HOME	$ 230,014.16	$ 230,014.16
3.	24-02-300-048-0000	NURSING HOME	$ 115,007.03	$ 115,007.03
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 385,000.35	$ 385,000.35

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 68,246 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	RESIDENT CARE		1996	$ 50,000	1
2					2
3	TOTALS			$ 50,000	3

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	249		1996	1976	$ 6,402,500	$ 164,160	30	$ 164,160	$	$ 1,715,530	4
5					(359,068)						5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS			1987	65,253		20	3,263	3,263	57,744	9
10	BUILDING IMPROVEMENTS			1987	16,408		19	864	864	6,911	10
11	BUILDING IMPROVEMENTS			1987	1,924		15			1,924	11
12	BUILDING IMPROVEMENTS			1987	7,771		5			7,771	12
13	BUILDING IMPROVEMENTS			1988	9,570		20	479	479	7,519	13
14	BUILDING IMPROVEMENTS			1988	6,960		19	366	366	6,080	14
15	BUILDING IMPROVEMENTS			1989	7,955		20	398	398	3,509	15
16	BUILDING IMPROVEMENTS			1989	5,500		15	189	189	5,500	16
17	BUILDING IMPROVEMENTS			1990	34,570		20	1,729	1,729	25,390	17
18	ELECTRICAL			1991	1,658		31.5	53	53	726	18
19	ELEVATOR			1991	75,000		31.5	2,381	2,381	28,952	19
20	REMODELING			1991	3,668		31.5	116	116	1,513	20
21	ALARM DETECTION			1992	2,700		31.5	86	86	497	21
22	CURTAINS & TRACKS			1992	16,416		31.5	521	521	6,447	22
23	BUILDING IMPROVEMENTS			1993	63,956		39	1,640	1,640	19,937	23
24	BUILDING IMPROVEMENTS			1994	3,221		39	83	83	871	24
25	BUILDING IMPROVEMENTS			1994	3,500		39	90	90	945	25
26	HOT WATER HEATER			1994	1,985		39	51	51	535	26
27	BUILDING IMPROVEMENTS			1995	9,054	232	39	232		2,204	27
28	REPLACE FLOORS IN ENTIRE FACILITY			1996	63,110	2,104	30	2,104		17,884	28
29	WALLPAPERING			1996	3,646	122	30	122		1,037	29
30	DRAPERY & CURTAINS			1996	12,244	408	30	408		3,468	30
31	PAVEMENT - DRIVEWAY			1996	6,600	220	30	220		1,870	31
32	REMODELING SHOWER ROOMS, BATHROOM & REHAB ROOMS			1996	171,960	5,732	30	5,732		47,400	32
33	NEW LOBBIES & NURSING STATION			1997	69,250	1,776	39	1,776		12,987	33
34	KITCHEN ELECTRICAL			1997	3,578	92	7	511	419	3,623	34
35	FIRE DOOR			1997	520	13	7	74	61	525	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	AIR CONDITIONER	1997	$ 2,205	$ 57	39	$ 57	$	$ 427	37
38	TIME CLOCK SYSTEM	1998	4,958	127	39	127		826	38
39	PLUMBING	1998	5,398	138	39	138		897	39
40	AIR CONDITIONING	1998	4,239	109	39	109		708	40
41	ROOF	1998	1,562	40	39	40		260	41
42	TUCKPOINTING	1999	1,917	49	39	49		270	42
43	FIRE ALARM	1999	1,420	36	39	36		198	43
44	FENCE	1999	3,367	86	39	86		473	44
45	WINDOWS	1999	4,677	120	39	120		660	45
46	HVAC WORK	1999	2,946	76	39	76		418	46
47	PAINTING	1999	42,104	3,756	7	6,015	2,259	33,082	47
48	WALLPAPER	1999	4,804	429	7	686	257	3,773	48
49	CUBICLE CURTAINS	1999	17,937	1,600	7	2,562	962	14,091	49
50	DRAPES	1999	2,436	217	7	348	131	1,914	50
51	CARPETING	1999	2,788	249	7	398	149	2,189	51
52	FIRE DAMPERS	2001	1,190	31	39	31		93	52
53	ROOFING	2001	2,838	73	39	73		219	53
54	FLOORING	2001	5,320	137	39	137		410	54
55	EXTERIOR BRICK	2001	300	8	39	8		24	55
56	DISCHARGE VENTS	2001	6,948	176	39	176		530	56
57	WINDOWS	2001	1,680	43	39	43		129	57
58	WINDOWS	2001	1,550	40	39	40		120	58
59	ELEVATOR	2001	5,972	153	39	153		459	59
60	WIRING & PIPES	2001	8,766	225	39	225		675	60
61	ELECTRICAL	2001	158	4	39	4		12	61
62	SPRINCLER SYSTEM	2001	1,424	37	39	37		111	62
63	ROOFING	2001	566	15	39	15		45	63
64	CARPET	2001	1,683	43	39	43		297	64
65	CARPET	2001	434	11	39	11		76	65
66	HANDRAIL	2001	23,600	605	39	605		4,175	66
67	NURSING STATION	2001	6,000	154	39	154		1,062	67
68	HANDRAIL	2001	16,800	431	39	431		2,433	68
69	FRONT HALLWAY	2001	2,400	62	39	62		726	69
70	TOTAL (lines 4 thru 69)		$ 6,901,796	$ 184,196		$ 200,743	$ 16,547	$ 2,061,081	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,901,796	$ 184,196		$ 200,743	$ 16,547	$ 2,061,081	1
2	FRONT RECEPTION	2001	4,800	123	39	123		849	2
3	ELEVATOR	2001	3,900	100	39	100		690	3
4	HANDRAIL	2001	11,800	303	39	303		2,089	4
5	EMPLOYEE KITCHEN	2001	1,900	49	39	49		337	5
6	NURSING STATION	2001	10,000	256	39	256		1,068	6
7	ELEVATOR IMPROVEMENTS	2002	2,422	62	39	62		181	7
8	ROOFING	2002	2,838	73	39	73		207	8
9	FLOOR REMODELING	2002	4,756	122	39	122		356	9
10	FLOOR REMODELING	2002	3,807	98	39	98		278	10
11	FLOOR REMODELING	2002	11,296	290	39	290		846	11
12	ALARM SYSTEM-INSTALL SEVEN KEYPAD	2003	4,181	152	27.5	152		222	12
13	FLOOR REMODELING-2RD & 2ND FLOOR BEDROOMS	2003	44,266	1,610	27.5	1,610		2,214	13
14	ELEVATOR-REPLACEMENT CYLINDER	2003	36,057	1,311	27.5	1,311		1,694	14
15	PARKING LOT-SEALCOATING, PRAVACY FENCE & GATE	2003	7,147	476	15	476		555	15
16	REPLACE OLD CUBICLE RODS, MINI BLINDS	2003	8,012	2,564	20	401	(2,163)	802	16
17	REMODEL SHOWER ROOMS	2004	51,140	1,783	27.5	1,783		1,783	17
18	INSTALL NEW OUTLETS	2004	10,330	329	27.5	329		329	18
19	SAF-T-LOK SYSTEMS	2004	5,955	190	27.5	190		190	19
20	NURSING CALL SYSTEMS - 1ST & 2ND FLOOR	2004	29,646	674	27.5	674		674	20
21	FIRE DOOR	2004	4,005	91	27.5	91		91	21
22	FLOORING - DISHWASHING AREA	2004	9,860	254	27.5	254		254	22
23	WIRING FOR CONDENSERS	2004	8,400	140	27.5	140		140	23
24	STAIR TRACKS & RUBBER TILE	2004	3,446	47	27.5	47		47	24
25	A/C SYSTEMS - 1ST & 2ND FLOOR	2004	39,244	297	27.5	297		297	25
26	REPAIR NURSING CALL SYSTEM - 3RD FLOOR	2004	10,232	47	27.5	47		47	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,231,236	$ 195,637		$ 210,021	$ 14,384	$ 2,077,321	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 537,983	$ 78,634	$ 64,539	$ (14,095)	8-10	$ 260,869	71
72	Current Year Purchases	26,949	16,170	1,348	(14,822)	8-10	1,348	72
73	Fully Depreciated Assets	465,942					465,942	73
74	RELATED PART ALLOCATION		703	703				74
75	TOTALS	$ 1,030,874	$ 95,507	$ 66,590	$ (28,917)		$ 728,159	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	DODGE VAN	2002	$ 27,499	$ 3,696	$ 5,500	$ 1,804	5	$ 16,500	76
77										77
78										78
79										79
80	TOTALS			$ 27,499	$ 3,696	$ 5,500	$ 1,804		$ 16,500	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,339,609	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 294,840	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 282,111	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (12,729)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,821,980	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A -RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 19,296 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2002 BUIK PARK AVEN	$ 568.00	$ 6,861	17
18	MAINTENANCE	2004 PONTIAC TRUCK	651.00	2,886	18
19	ADMINISTRATIVE	2004 CHRYSLER TOWN	700.00	5,599	19
20					20
21	TOTAL		$ #######	$ 15,346	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 213,495	$		$ 213,495	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			82,518			82,518	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			67,059			67,059	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				227,071		227,071	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): RADIOLOGY, LAB	39-2					9,296		9,296	13
14	TOTAL			$		$ 363,072	$ 236,367		$ 599,439	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 55,193	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,189,456		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	88,283		6
7	Other Prepaid Expenses	307,351		7
8	Accounts Receivable (owners or related parties)	902,506		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,542,789	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,123,754		15
16	Equipment, at Historical Cost	1,122,422		16
17	Accumulated Depreciation (book methods)	(1,207,871)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): GOODWILL	244,323		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,282,628	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,825,417	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 205,219	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	923,264		29
30	Accrued Salaries Payable	162,925		30
31	Accrued Taxes Payable (excluding real estate taxes)	58,834		31
32	Accrued Real Estate Taxes(Sch.IX-B)	388,850		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,739,092	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,739,092	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,086,325	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,825,417	$	48

*(See instructions.)

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,949,972	1
2	Restatements (describe):		2
3	POST CLOSING ENTRIES	(9,206)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,940,766	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	429,559	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(284,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 145,559	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,086,325	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,386,827	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,386,827	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	134,903	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 134,903	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	275	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 275	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,522,005	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,456,271	31
32	Health Care	2,974,790	32
33	General Administration	1,655,891	33
	B. Capital Expense		
34	Ownership	1,269,353	34
	C. Ancillary Expense		
35	Special Cost Centers	599,439	35
36	Provider Participation Fee	136,702	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,092,446	40
41	**Income before Income Taxes (line 30 minus line 40)****	429,559	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 429,559	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,167	4,426	$ 141,021	$ 31.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,287	6,567	146,873	22.37	3
4	Licensed Practical Nurses	47,773	50,096	1,017,089	20.30	4
5	Nurse Aides & Orderlies	103,814	109,361	871,625	7.97	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,078	5,443	62,061	11.40	8
9	Activity Director					9
10	Activity Assistants	16,937	17,482	138,006	7.89	10
11	Social Service Workers	25,955	26,677	264,489	9.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	33,421	34,999	264,016	7.54	15
16	Dishwashers					16
17	Maintenance Workers	6,638	6,747	71,966	10.67	17
18	Housekeepers	30,393	32,012	296,841	9.27	18
19	Laundry	10,595	11,588	91,143	7.87	19
20	Administrator	3,089	3,141	121,117	38.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,250	10,739	111,789	10.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) SEE ATTACHED	17,177	18,314	217,271	11.86	33
34	TOTAL (lines 1 - 33)	321,574	337,592	$ 3,815,307 *	$ 11.30	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 12,323	1-3	35
36	Medical Director	monthly fee	12,000	9-3	36
37	Medical Records Consultant	monthly fee	4,128	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	monthly fee	12,702	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant	monthly fee	15,850	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	monthly fee	2,730	11-3	44
45	Social Service Consultant	monthly fee	5,300	12-3	45
46	Other(specify) DENTAL	monthly fee	3,700	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 68,733		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses	N/A	0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
YOSEF MEYSTEL	ADMIN	0	$ 121,117
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 121,117

B. Administrative - Other

Description		Amount
EMI ENTERPRISES	MANAGEMENT FEE	$ 46,000
MARVIN MERMELSTEIN	MANAGEMENT FEE	10,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 56,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		75,319
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 75,319

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 129,249
Unemployment Compensation Insurance		109,079
FICA Taxes		288,091
Employee Health Insurance		126,254
Employee Meals		11,621
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		2,369
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		36,916
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 703,579

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,490
Advertising: Employee Recruitment	2,854
Health Care Worker Background Check	1,680
(Indicate # of checks performed 120)	
MARKETING/ADV/PROMO	0
TRUST/FRANCHISE/CONTRIB/ETC	5,257
LICENSES & PERMITS	713
DUES & SUBSCRIPTIONS	9,465
MGMT CO ALLOCATION	1,384
TRUST/FRANCHISE/CONTRIB/ETC	(5,257)
Less: Public Relations Expense	(0)
Non-allowable advertising	(0)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,586

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	5,331
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,331

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING/DECORATIN	7/03	$ 11,677	3 YRS	$	$	$ 1,946	$ 3,893	$ 3,892	$ 1,946	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 11,677		$	$	$ 1,946	$ 3,893	$ 3,892	$ 1,946	$	$	$

Facility Name & ID Number EMERALD PARK HEALTH CARE CENTER # 0040816 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $8,939**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,131** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **136,702**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **11,621** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees